CHAPTER OVERVIEW

Developmental and psychological problems are more prevalent in children and adults who have suffered maltreatment, and you will find a larger percentage of these problems in your families than in the general population. This chapter is meant to provide the family Children's Service Worker some specific information on these problems so they may better serve their families.

Children's Service Workers are not expected to diagnose conditions, developmental disabilities, or psychological disabilities. However, it is important that you are able to recognize them, understand how these problems affect the family, and know where to look for help.

MENTAL RETARDATION & DEVELOPMENTAL DISABILITIES

Mental Retardation of Parent

It is possible for individuals who are mentally retarded to give their children proper care. However, in many cases the parent will need assistance.

Mentally retarded or developmentally delayed adults who are mainstreamed in the community may seldom admit to their disability, and the Children's Service Worker will need to rely on his/her own observation as well as information from other family members or collateral. Observations might include lack of reading ability, childlike behavior, lack of understanding, inability to solve problems or make decisions, inability to deal with abstracts, and speech difficulties.

In working with a parent that is developmentally delayed, special attention should be given to speaking in terms that can be understood. Do not talk "down" to them, but use common words and approach one subject at a time. Rather than asking "Do you understand?", which is nonproductive and demeaning, find ways for them to repeat back to you what has been discussed.

In teaching new skills, everything should be taken one step at a time. Each task is made up of many individual parts. Making a bed is one task, however, if you are teaching a mentally retarded individual to perform that task, you must teach 12 different steps. Instructions would range from taking the pillow off the bed, through pulling up and straightening sheets and blankets, to putting the pillow back on the bed and covering with bedspread. For someone less handicapped, you might break it down to three or four steps. With little effort the Children's Service Worker can break down the skill they want to teach into individual parts. Always be sure each part is understood before moving on.

In summary, any housekeeping chore that does not require reading or numbers can be taught to a mentally retarded adult. It just takes longer, which makes the term "slow learner" very appropriate.

There will be times when the lack of being able to read, tell time, or use numbers seems a major stumbling block to a retarded parent's care of his/her children. With a little effort, most of these problems can be overcome.

Example: The parent of a newborn is unable to read the ounces on a baby bottle. The Children's Service Worker can paint a line on the bottle at the proper level.

Example: The child is ill and needs medication every eight hours, and parent cannot tell time. Have medicine given when they get up in the morning, at lunch, and at bedtime.

Example: A baby is failure to thrive; the infant is to be fed four ounces every three hours. The Children's Service Worker has already marked bottles and taught mother to mix formula by filling a jar with water to the line marked by the worker, and mixing with one can of milk. Mother cannot tell time and baby is passive. The worker can put marks on the clock at 12, 3, 6, and 9, or purchase a timer, or if parent is a TV watcher, use times that different programs are on as guidelines.

Some problems cannot be overcome without a support system, and these become more apparent as the children get school age. If a note comes home from school and the child cannot tell the parent what it says, it will probably be thrown away. This may result in the parent being incorrectly labeled as uncooperative. These are problems that must be dealt with on an individual basis, depending on the support system and cooperation from school and others.

In families where the mother is mentally retarded and the children are of normal intelligence, you will begin to see role reversal when the oldest child reaches the developmental level of the mother. At this point you may have problems with the child deciding not to go to school, and will need to have cooperation from the entire family in encouraging regular school attendance.

There may be parents who, due to severe mental retardation and/or lack of support system, are unable to care properly for their children, even with intervention by Children's Division (CD), and the Children's Service Worker needs to recognize that and not feel that they have failed.

Services in Behalf of the Parents

Services to assist parents who are mentally retarded to learn parenting skills or to counsel such parents are relatively new. Programs exist in the two major metropolitan areas in the state. (In St. Louis there is a program called "Life Skills" which teaches retarded adults, and a similar program in Clay and Platte Counties is operated by "Concerned Care, Inc.")

Other services which may be useful include:

- A referral for evaluation and diagnosis;

- A referral to one of the regional centers of the Missouri Division of Mental Retardation and Developmental Disabilities. Every county in the state is serviced by one of these centers. The centers offer services directly and administer contracts with service vendors. If agencies are found who can counsel and teach parenting skills to mentally retarded adults, then they should be encouraged to apply to become contractors for CD as well;

- Parent aide services, when fundamental parenting skills are absent;

- A referral to the Association for Retarded Citizens (ARC). This organization is a source of information on programs and, in some localities, may itself offer programs in parenting skills for mentally retarded adults who have children;

- Counseling, particularly in-home counseling, by someone who has expertise in working with retarded citizens;

- Respite care may be considered for cases in which the parent needs time off from the stress of parenting.

Mental Retardation or Developmental Disability of Child

Mental retardation and developmental disabilities are found in greater proportion among children who have been abused or neglected than among the non-CA/N population. It appears that in some cases the retarded or otherwise handicapped child may be the object of abuse or neglect. In other cases it may be that the mental retardation or delays result, at least in part, from the abuse or neglect. In any event it is likely that significant numbers of children who are abused or neglected are also mentally retarded or developmentally disabled.

Handicapped children affect the entire family. As a general rule, they take more of their parents' time. When a family first learns they have a retarded child, they will need a great deal of support. Sometimes one parent will blame the other for the problem. Counseling is strongly recommended if you are involved with a family at this stage.

Detecting the presence of mental retardation and other disabilities will involve one or more of the following steps:

- Discussion of the child's development with the parents, especially any problem areas which the parents perceive, covering the following areas:

  - Speech/language;

  - Hearing;

  - Vision;

  - Orthopedic;

- Learning disabilities;
- Emotional behavior;
- Appearance; and
- Other problems (i.e., epilepsy, cerebral palsy);

- Discussion of the child's health history with the parents;
- Contact with teachers and counselors for information on school progress, for school age children;
- A referral for a cognitive screening, provided by a qualified provider, to confirm if the child is mentally delayed.

Most of the developmentally delayed children in your families will be functionally delayed, which means they are slow because of lack of proper stimulation or physical neglect. Because of this it is important for the Children's Service Worker to be aware of developmental levels of preschool age children.

Related Subject: Chapter 4, of this section, Developmental Milestone.

If you find a child who is functioning slightly below age level, attention should be paid to what stimulation is being offered the child. Is he being talked to, taken outside, meeting people other than the immediate family, or offered age-appropriate toys? If not, suggestions should be made to correct the situation. Many toys can be made of items around the house. Some examples would be different sized food cans, clean and washed and nestled inside one another or stacked, jar rings strung on a shoestring, clothes pins to put in or put on a can, empty pill bottles filled with beans or rice to shake, and play-dough made of flour, salt, and water.

Observation should also be made of proper nutrition, sleep habits, and other health related problems.

If the preschool child seems to be functioning well below age level, referral should be made to the Regional Diagnostic Center for evaluation. There is a regional center servicing every county in the state. Preschool is highly recommended for any child who is functioning below age level. Some communities have special preschools. Head Start is mandated to take a certain number of handicapped children, although schooling for these children should start before the age of four.

The Children's Service Worker should help the parents have realistic expectations of their child, according to their own ability. Special note should also be given to the interaction of the siblings. The handicapped child may be the scapegoat of the family, or may be getting so much attention that the other children are not getting their share and

will need their own special time with the parent. Above all, the family should be encouraged to understand that having a happy, loving child will reap its own rewards for the child and the family, regardless of ability.

There are a few families who will have a profoundly retarded child who will also have physical handicaps. These children will need constant medical care, and weekly visits from visiting nurses will be of great help. This must be requested by the child's physician, but the Children's Service Worker should feel free to make that suggestion.

The school age child who is developmentally delayed will be evaluated by the school. Any child who is receiving special services in school will have a semi-annual IEP (Individual Educational Program). This is a meeting of all involved school personnel and the family. These meetings are sometimes very intimidating to parents, and if the parent would like the moral support of the Children's Service Worker, attendance at these meetings is encouraged. There is an appeal process built into the system, if the parents do not agree with the IEP. Close communication between school and home should be encouraged where there is a child receiving special services. You may request reports on psychological testing and evaluation. If it is coming from the schools or sources other than CTS providers, you will need a release signed by the parent. When reading the results of these tests, it is beneficial to know the names of the tests that have been administered and what they are to show.

There are numerous books in the public library on how to parent mentally retarded children. Developmental delays and metal retardation are sometimes diagnosed as specific conditions. Although the previous information is appropriate for all forms, there will be times when the Children's Service Worker will need definitions, which may be found in the glossary.

Services in Behalf of the Child

In addition to the above, the following services should be considered:

- Evaluation and diagnosis can be sought for cases in which the Children's Service Worker suspects mental retardation or developmental disabilities, yet the child has not been diagnosed as such in the past;

- Referral to the regional centers of the Missouri Division of Mental Retardation and Developmental Disabilities. Available throughout the state, these centers provide complete evaluative and diagnostic services, as well as case management based on an Individualized Habilitation Plan (IHP). Other services such as infant stimulation/early childhood education, specific habilitation and medical services, and respite care may also be available.

- Home-based services to provide instructions on infant and child stimulation (i.e., Parents as Teachers Program).

- A special or therapeutic preschool, including day treatment or day care facilities which can meet the child's needs;
- Respite care;
- Counseling or parent aide services for the parents.

PSYCHOLOGICAL PROBLEMS

Psychological Problems of the Parent

It is possible for individuals who are mentally ill to rear their own children. However, the prognosis is not as good as with mentally retarded parents.

You will probably find families with a member that has psychological problems to be among the more frustrating families to work with. It is important to remember that persons with true psychological problems do not act irrationally because they want to, but because they are unable to control those behaviors. They will no doubt be more frustrated than you. As a Children's Service Worker, you cannot cure emotional or mental illness, but there are things that you can do.

Mental Illness

The mentally ill persons that you will be most apt to find in your caseload will fall into the following categories:

- Depression;
- Bipolar;
- Schizophrenia;
- Other psychoses; or
- Anxiety disorder.

Mentally ill individuals will need to be under a psychologist or psychiatrist's care. The client should sign a release of information form so that the Children's Service Worker can discuss the client and family's situation with the doctor. The worker can help in seeing that appointments are kept, and can monitor drug usage.

It is possible that a parent with one of these disorders may be unable to keep their children from being removed, even with concentrated efforts from the Children's Service Worker, unless there is another well-adjusted and available parent in the home. The following are examples of how the worker might help certain families.

Example: You have a family where the mother is severely depressed. She does not sleep well at night, and the depression takes away her motivation to do the simplest household chores. The husband comes home from work and is naturally upset to see the breakfast dishes undone, the wife still in her nightgown, and supper not started. He calls his wife lazy, a fight ensues, and he leaves the house. The wife becomes even more depressed by the events, and the cycle continues to escalate. The Children's Service Worker can explain the symptoms of depression and give the husband concrete suggestions on how to handle the situation. Suggestions may include encouraging her to get dressed and take a short, brisk walk together, or offer to clean up the kitchen while she starts dinner, and offering hope that tomorrow will be better.

Example: You have a mother in your caseload that is psychotic. She is under a doctor's care, and as long as she is medicated at the proper level, she is capable of taking care of her children. The Children's Service Worker needs to keep track of the monthly doctor appointments and ensure that someone is responsible for her keeping those appointments. This mother sometimes decides to increase or decrease the medication, according to how she feels. These drugs are almost always prescribed by the week or the month. The worker can monitor medication by counting pills. A parent aide who can be in the home more frequently could do this, or if there is someone in the family who can dispense the medication, that is ideal. If there is a father in the family, he may need to carry the extra medication on his person so that it is unavailable when he is gone from the home.

Example: A young mother keeps her shades down and windows shut. She will not venture outside. Her two-year-old son is only seeing the sunshine on weekends when dad will take him outside. Mother believes neighbors are watching her, and suffers severe anxiety when her husband is gone. After the Children's Service Worker has developed a relationship with the mother, by helping her teach her 18-month-old some new skills, a plan is developed where one shade is raised one inch during a visit, with the worker there as support. An inch is added each visit. The child is delighted at looking outside. Expect periodic setbacks, when the mother will be too anxious to allow the shade to be raised at all. In the case cited here, the mother was eventually able to have the shades up and windows open, which improved her depression, and eventually she was able to go outside.

Psychological and Emotional Deficits

Much more common than the severe mental problems discussed previously are the more common ones that most people experience at some time. Those are sometimes called "situational psychological problems." This category would include depression due to external stresses, such as loss of a loved one, an alcoholic or abusive mate, loss of employment, or loss of housing. Adult survivors of abuse or neglect may have poor self-image that will keep them from

functioning at full potential. Alcohol and drug abuse would fall into this category, and will be addressed in another chapter. Other problems are anxiety, eating disorders, feelings of persecution, and inability to handle stress. Most of these families can be helped with a team approach, including a psychologist or therapist on the team.

Example: The paramour of the mother is an alcoholic and beats on her when drinking. Income is unreliable due to drinking. Mother is depressed and ill a great deal. The Children's Service Worker is in a position to find the family's strong points and build on those to improve the mother's self-image. A parent aide could be used if the worker does not have at least two or three hours a week to spend with this family. Counseling should be authorized with CTS funds, and Al-Anon should be recommended. The worker should recommend job training or schooling for the mother and help her through that process. If there are preschool children who are showing symptoms of living in a dysfunctional family, day care can also be supplied with CTS funds. As the family becomes more self-sufficient, the paramour may become more abusive, and plans for the safety of the family should be discussed.

Referrals to Mental Health Coordinators

A mental health coordinator is a mental health professional who works for the state department of Mental Health and is assigned to a specific region within the state. Refer to the map below.

MENTAL HEALTH COORDINATOR SERVICE

	LOCATION	**SERVICE AREAS (COUNTIES)**		
1.	Northwest Missouri Psych Rehab Center 3505 Frederick Avenue St. Joseph, MO 64506 (816) 671-7064	Andrew Atchison Buchanan Caldwell	Clinton Davies Dekalb Gentry	Harrison Holt Nodaway Worth
2.	Kirksville Regional Center 1702 E LaHarpe, Box 265 Kirksville, MO 63501 (660) 785-2555	Adair Chariton Grundy Linn	Livingston Macon Mercer Putnam	Randolph Schuyler Sullivan

	LOCATION	**SERVICE AREAS (COUNTIES)**		
3.	Tower Plaza Office Building	Clark	Marion	Ralls

	655 Clinic Road, Suite 2 Hannibal, MO 63401 (573) 248-2470	Knox Lewis	Monroe Pike	Scotland Shelby
4.	Western Missouri Mental Health Center 600 E 22nd Street Kansas City, MO 64108 (816) 512-4620	Cass Clay Jackson	Johnson Lafayette	Platte Ray
5.	Mid-Missouri Mental Health Center #3 Hospital Drive Columbia, MO 65201 (573) 884-0958	Boone Carroll Cooper	Howard Moniteau Morgan	Pettis Saline
6.	Fulton State Hospital 600 East Fifth Street Fulton, MO 65251 (573) 592-3071 or 592-3072	Audrain Callaway Camden	Cole Gasconade Maries	Miller Montgomery Osage
7.	St. Louis Psychiatric Rehab Center Dome Building 5400 Arsenal, MSA 130 St. Louis, MO 63139 (314) 877-0330 or877-0331	Franklin Jefferson Lincoln	St Charles St Louis City	St Louis County Warren
8.	Southwest Mo Mental Health Center 2201 N Elm, Room 46 Nevada, MO 64772 (417) 448-3467 or 448-3453	Barton Bates Benton Cedar	Henry Hickory Jasper McDonald	Newton St Clair Vernon
9.	Southwest Regional Office 1915 B West Sunshine Springfield, MO 65807 (417) 895-6326 or 895-6544	Barry Christian Dade Dallas	Greene Lawrence Polk	Stone Taney Webster
	LOCATION	**SERVICE AREAS (COUNTIES)**		
10.	Family Services Building P.O. Box 78, N Highway 63 Houston, MO 65483	Carter Dent Douglas Howell	Oregon Ozark Phelps Pulaski	Ripley Shannon Texas Wright

	(417) 967-3125	Laclede		
11.	Southeast Mo Mental Health Center 1010 W Columbia Farmington, MO 63640 (573) 218-7013 or 218-7014	Crawford Iron Madison	Perry Reynolds St Francois	Ste Genevieve Washington
12.	Cottonwood RTC 1025 N Sprigg Cape Girardeau, MO 63701 (573) 290-5924	Bollinger Butler Dunklin Cape Girardeau	Mississippi New Madrid Pemiscot	Scott Stoddard Wayne

Mental health coordinators investigate persons (adults) alleged to be mentally disordered and dangerous to themselves and others. They can be asked to assist in or independently investigate situations that a Children's Service Worker feels is potentially physically harmful to a person or someone else due to an alleged mental disorder or alcohol/drug abuse. If the situation warrants, they can have the person removed from the situation immediately and arrange admission to a mental health or alcohol/drug abuse facility. They can also provide consultation and training, give information regarding facilities in the area, financial provisions needed for admission, admission procedures, etc.

Psychological Problems of Children

Psychological problems of children can contribute to abuse and neglect, as it will always affect the entire family. These are among the most difficult problems in parenting, especially if the parents have no understanding of the problem, or training in how to handle difficult children.

The most common psychological problem found in preschool children is hyperactivity, also known as attention deficit hyperactivity disorder. The family will likely see this child as a "bad" child, and the child will become even more disturbed unless there is intervention and special training.

Emotionally disturbed/behavior disordered children show one or more of the following patterns of behavior:

- An inability to learn which will not be adequately explained by intellectual, sensory, neuro-physiological, or general health factors;
- An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
- Inappropriate or immature types of behavior or feelings under normal conditions;

- A general pervasive mood of unhappiness or depression;
- A tendency to develop physical symptoms such as speech problems, pains or fears associated with personal or school problems; and
- Eating disorders.

Because emotionally disturbed/behavior disordered children do not do well in school, they are sometimes seen as being slow or troublemakers. The Children's Service Worker can help the parents by encouraging their cooperation with the child's school, and helping them in understanding and coping with information received from the school.

Psychological counseling becomes much more effective with school age children; however, when the Children's Service Worker is contracting with a therapist, care needs to be taken in finding one that works well with children.

As with the preschool child, the parents need to be taught the importance of routine, consistent responses to misbehavior, and finding positive behaviors to build on. Hyperactivity will begin to diminish at around seven years of age, but other behaviors will likely develop, such as aggressiveness, wide mood swings, sleeping and eating disorders, and depression.

Behavior modification may be effective. There are also some good books in your local library.

Related Subject: Chapter 3, of this section, Parenting and Discipline.

Some children will remain out of control in spite of intervention. There are now many good children's psychiatric hospital units across the state that will do 30-day inpatient evaluations, and take the parent's health insurance or Medicaid for payment. These evaluations should help in developing a treatment plan for the child. Reports from psychiatrists will contain many terms that you will be unfamiliar with, such as "attention deficit," "disassociative disorders," etc.

Example: A single parent family has three young teen and pre-teenage boys. The youngest child has had behavior problems for many years. Treatment services have been given to the family from time to time. There is a protective service case open at this time, and the boy is in counseling with CTS funds, and is in special classes at school. The Children's Service Worker makes a scheduled home visit and finds the boy out of control. The mother reports the boy has stomped on and broken his brother's new birthday bike, he has held a knife to his brother's stomach, and has threatened his mother with his fist. The mother declares she can't take any more. Although the worker has developed a good relationship with the troubled child, he appears to be beyond the ability of rational thought at this time. During the visit he alternates from standing outside screaming obscenities at mother, worker, neighbors, etc., to sitting at the table with his head down, whimpering that nobody loves him. This child is in need of hospitalization, and the worker needs to help the family find an appropriate placement

and be supportive throughout the placement period. The worker should be involved in the discharge staffing and treatment plans for aftercare.

MENTAL DISORDERS COMMON TO CHILDREN

This chapter provides brief definitions of a variety of mental illnesses in children and should be used only as a source of general information. The Children's Service Worker should consult with the family/child's mental health professional regarding specific diagnoses and recommended treatment/therapy.

"Mental illness" is a term used for a group of disorders causing severe disturbances in thinking, feeling, and relating to others. Adults and children with a mental illness have a substantially diminished chance of coping with the ordinary demands of life.

Mental illness is not the same as mental retardation, which is a lowered intellectual ability usually from birth. Children with mental illness usually have normal intelligence, but they may have difficulty using their whole intellect because of their illness.

Disorders and Their Symptoms

Mental illness in children falls into two basic categories, according to The American Psychiatric Association, Behavioral Disorders and Emotional Disorders. These categories are divided further and explained in the Diagnostic and Statistical Manual of Mental Disorders (fourth edition, revised).

This reference book, used to help make diagnoses, defines a "mental disorder" as "... a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more areas of functioning (disability)."

Disorders run the gamut from intellectual disorders, such as mental retardation to developmental disorders, such as autism. Disorders can be behavioral and emotional and physical, and they can be made worse by stress, such as death of a loved one or drug or alcohol abuse, according to "Children's Mental Health; Problems and Services," a publication of Duke University. The following brief definitions only begin to suggest the range and pattern of mental disorders, but can be helpful in understanding diagnoses.

Disruptive Behaviors

- Attention-Deficit/Hyperactivity Disorder (ADHD or ADD) - Children with attention-deficit disorder fail at being attentive in school and at home. Sometimes these children are also hyperactive, that is, unable to stop fidgeting. Other symptoms include difficulty remaining seated, staying focused, waiting turns, and following instructions. These children often shift from one unfinished task to another equally unfinished project. They talk a lot, often interrupting beyond the norm of children's need to be heard right away. Children with this disorder often respond to medication and therapy.

- Conduct Disorder - Adolescents whose behavior persists in poor conduct show no respect for the space and energy of others. They refuse to do their share of work and will not negotiate. They break rules, such as curfews, constantly. They fail to establish affection or bond with others, however, they may have superficial relationships with other teens. They can be selfish (egocentric) and manipulative, and they feel no remorse or guilt for misdeeds. Also, they can be cruel to animals and people.

- Adolescents who are aggressive engage in physical violence against others, i.e., vandalizing, setting fires, raping and murdering. Adolescents who are passive, break rules, run away from school and home, and abuse drugs and alcohol.

- An attention-deficit disorder can be accompanied by hyperactivity, so conduct disorder can be accompanied by "oppositional behavior," which includes blaming others, arguing often, and deliberately doing things that annoy other people. When the anti-social behavior is consistent, "it is unlikely that they will simply grow out of it," Dr. Alan E. Kazdin, a professor of psychology at Yale University, stated in The Psychiatric Hospital.

- Oppositional Disorder - Aggressively stubborn and obstinate, basically passive. Children with this disorder seem to be conforming, but their dawdling and negativity veil their aggression.

Mood Disorders

- Depression - This disorder refers to a mood or a set of symptoms, including insomnia, loss of appetite, slower activity and speech, tiredness, poor concentration and suicidal thoughts. Often, depressed children show behavioral problems as well, so separating the two for diagnosis can be difficult.

- Bipolar Disorder - Children with this illness usually display several of the following: boundless energy and enthusiasm; decreased need for sleep; grandiose ideas and poor judgment; rapid, loud disorganized speech; short temper and feistiness; impulsive and erratic behavior; delusional thinking (hallucinations); and rapid switch to severe depression.

Anxiety Disorders

- Anxiety disorders refer to a wide range of inappropriate responses, often exaggerated, to the perception of danger, inner or outer. The responses can be affective (emotions), cognitive (thinking), motor (movement) or physiological (physical symptoms).

- Separation Anxiety - It is natural for children to be afraid of going to school because school is new and foreign. It is not natural for children to be so scared that they panic, afraid of unrealistic calamities such as being kidnapped or killed, and cannot be calmed unless allowed to stay home. These children often have nightmares about separation. The longer they stay home, the more impaired their social and educational growth becomes.

- When the separation anxiety centers on school, the label is "school phobia."

- Avoidant Disorder - Children and adolescents avoid establishing new contacts with other people or ordinary relationships with strangers to the degree that they lose touch with society.

- Over anxious Disorder (Panic Disorder) - Some children worry themselves sick for no apparent reason or stimulus. They fret about tests, possible injuries, friends and acceptance. They may have physiological symptoms such as headaches, hyperventilation (shortness of breath), dizziness, and nausea.

Other Disorders

- Borderline Personality Disorder (BPD) - Symptoms include marked mood swings with periods of intense depression, irritability and/or anxiety lasting a few hours to a few days; inappropriate, intense, or uncontrolled anger; unstable interpersonal relationships; impulsiveness in spending, sexual activity, use of controlled substances, shoplifting, reckless driving, or binge eating; frantic efforts to avoid abandonment; and recurring suicidal threats or self-injurious behavior. Mental health professionals have been reluctant to label children with this disorder.

- Eating Disorders - Disturbance in body image with intense fear of gaining weight even though underweight - persistent and extreme concern with the weight and body's shape. Eating disorders are more common in females than males. Children with anorexia nervosa lose weight by not eating and excessive exercise. From 5 to 18 percent of adolescents with this disorder die. Children with bulimia nervosa lose weight by vomiting, often after bingeing (eating excessively), taking laxatives and/or diuretics, and over exercising.

- Neurobiological Disorder - Refers to problems stemming from brain malfunctions and malformations that can be proven and demonstrated. Through research in this broad area, scientists are discovering that causes of more and more mental illnesses are biological.

- Pervasive Developmental Disorder - Refers to a group of conditions involving deviations and delays in the child's developing social and motor skills, language, attention, perception, and the ability to test reality.

- Schizophrenic Disorders - Encompasses varying symptoms such as unreasonable fear of things real or imagined, auditory hallucinations (hearing voices), imagined illnesses, emotional flatness, lack of will, and delusions; refers to a psychotic disorder involving loss of contact with surroundings and loss of integrated personality (that is, all the pieces do not fall into place to form a whole person).

- Tourette's Syndrome - Often begins in childhood and lasts a lifetime; more often affects boys than girls. This neurological disease runs in families. Complex behavioral symptoms accompany tics in motor abilities (purposeless blinking, grimacing, shoulder jerking) and in speech (sniffling, barking, and speaking obscene words out of context).

Adapted with permission from Marge Parrish, Children with Behavioral and Emotional Disorders and Mental Illness - A Parents Guide: Edited by Marge Parrish for the Alliance for the Mentally Ill, Metropolitan St. Louis.

COMMON MENTAL HEALTH DISORDERS

Alcoholism - A behavioral disorder in which the consumption of alcoholic beverages is continuous and excessive, and impairs health and social and occupational functioning; a psychological dependence on alcohol.

Anorexia nervosa - Disorder in which a person is unable to eat or retain any food, or suffers a prolonged and severe decrease in appetite. The individual has an intense fear of becoming obese, feels fat even when emaciated. The person may also have symptoms of depression.

Anti-social personality - Also called a psychopath, or a sociopath, this person is superficially charming and a habitual liar, has no regard for others, shows no remorse after hurting them, has no shame for behaving in an outrageously objectionable manner, and is unable to form relationships and take responsibility.

Anxiety - An unpleasant feeling of fear and apprehension, accompanied by increased physiological arousal. Anxiety can be assessed by self-report, by measuring physiological arousal and by observing overt behavior.

Attention deficit /hyperactivity disorder - Developmentally inappropriate, inability to pay attention, and impulsiveness. DSM-4 term for hyperactivity reflecting the belief that hyperactive children suffer from diminished ability to attend to the task at hand.

Autism or Autistic Disorder - A neurological or biochemical brain disorder which impairs the development of physical, social, and language skills. The cause of this lifelong

condition is still unclear. Autism appears within the first three years of life and is found among children in every ethnic and social background. Five in ten thousand infants are autistic; it is four times more common in boys than in girls. The primary effect of autism seems to be difficulty in understanding messages from the senses, especially sight and hearing. This affects the child's ability to understand speech and to communicate. In addition to sight and hearing, autistic children frequently have unusual responses to other sensations; a child's sense of smell, taste, or reactions to touch or pain may be affected. Often the autistic child is very sensitive to bright lights or loud noises. Autistic children often exhibit unusual behavior patterns. They may appear to be very withdrawn, living in a world of their own, absorbed in self or fantasy as a means of avoiding communication and escaping objective reality. Usually they are unable to relate appropriately to other people.

Bipolar disorder - A term applied to the disorder of people who have experienced alternating episodes of both mania and depression.

Cerebral Palsy - A group of disorders caused by damage to the various muscle control centers of the brain. Approximately 10,000 babies are born each year in the United States with this condition, and 2,000 more children acquire it through head injuries. It is a result of brain damage before, during, or after birth. One of the most common causes is lack of sufficient oxygen reaching the fetal or newborn brain as a result of an unusual birth position, prolonged labor, or damage to the umbilical cord. In general, children with cerebral palsy have problems controlling motor functions. Gross motor skills such as sitting or walking may be difficult for the child with cerebral palsy. Development of fine motor skills, such as writing and eating, may also be hindered. There are many different types of cerebral palsy. Children with cerebral palsy may or may not be mentally retarded.

Conduct disorders - Patterns of extreme disobedience in youngsters, including theft, vandalism, lying, acts of aggression, and early drug use.

Dependent personality - Lacking in self-confidence, people with a dependent personality passively allow others to run their lives and make no demands on them, lest they endanger these protective relationships.

Depression - Emotional state marked by great sadness and apprehension, feelings of worthlessness and guilt, withdrawal from others, loss of sleep, appetite, and sexual desire, or interest and pleasure in usual activities, and with either lethargy or agitation. Called major depression in the DSM-4.

Developmental Disability - A severe. chronic disability of a person which (a) is attributable to a mental or physical impairment or combination of mental and physical impairment; (b) is manifested before the person attains age 22; (c) is likely to continue indefinitely; (d) results in substantial functional limitation in three or more of the following areas of major life activity: (1) self-care; (2) receptive expressive language; (3) learning; (4) mobility; (5) self-direction; (6) capacity for independent living; and (7) economic self-sufficiency; and (e) reflects the person's need for a combination and sequence of special

interdisciplinary or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

Disorientation - A state of mental confusion with respect to time, place, and identity of self, other persons, and objects.

Down's Syndrome - A common cause of mental retardation which interferes with the normal intellectual and physical development of a child. In the past, it has been called "mongoloidism," a term which is developmentally incorrect and should not be used. Down's Syndrome is caused from chromosomal abnormality, and shows in some observable physical characteristics. Although there is a wide range of mental ability within the Down's Syndrome population, most of these children will be considered severely retarded. Once school age, they usually will attend one of the state schools for the severely handicapped. Down's Syndrome children are in general very loving and cooperative, and are very easy children to teach.

DSM-4 - The current diagnostic and statistical manual of the American Psychiatric Association.

Dyslexia - Disturbance in the ability to read, one of the learning disabilities or specific developmental disorders.

Generalized anxiety disorder - One of the anxiety disorders. Anxiety is so chronic, persistent, and pervasive that it seems free-floating. The individual is jittery and strained, distractible and apprehensive that something bad is about to happen. A pounding heart, fast pulse and breathing, sweating, flushing, muscle aches, a lump in the throat, and an upset gastrointestinal tract are some of the bodily indications of this extreme anxiety.

Hyperactivity - A childhood disorder marked by an inability to inhibit movement and to concentrate in situations that call for it.

Learning Disabilities - Problems in mastering reading, arithmetic, or speech, that are not caused by mental retardation, impairment of visual or auditory functions, other psychological disorders, or cultural disadvantage. Called "Specific Developmental Disorders" in DSM-4.

Mental Retardation - Mental retardation means unusually slow or impaired learning ability, plus impairment in adaptive functioning (life-skills, social skills), and beginning before the age of 18, usually evident long before.

Neurosis - One of a large group of non-psychotic disorders characterized by unrealistic anxiety and other associated problems, for example, phobias, obsessions, compulsions.

Obsessive compulsive disorder - An anxiety disorder in which the mind is flooded with persistent and uncontrollable thoughts, where the individual is compelled to repeat

certain acts again and again, causing significant distress and interference of everyday functioning.

Paranoia - A general term for delusions of persecution, grandeur, or both, found in several pathological conditions. Essentially, a person believes his/her difficulties are intentionally caused by others. It can be produced by large doses of certain drugs, such as cocaine and alcohol.

Paranoid personality - This person, expecting to be mistreated by others, becomes suspicious, secretive, jealous, and argumentative. He or she will not accept blame and appears cold and unemotional.

Paranoid schizophrenic - Psychotic patient who has numerous systematized delusions, as well as hallucinations and ideas of reference. He/she may also be agitated, angry, argumentative, and sometimes violent.

Personality disorders - A heterogeneous group of disorders listed separately on axis II, regarded as long-standing, inflexible, and maladaptive traits which impair social and occupational functioning but do not impair contact with reality.

Psychological deficit: - Term used to indicate that performance of a pertinent psychological process is below that expected of an average person.

Psychosis - A severe mental disorder in which the individual is so seriously out of contact with reality that thinking and emotional responses are impaired.

Schizophrenia - A group of psychotic disorders characterized by major disturbances in thought, emotion, and behavior - disordered thinking in which ideas are not logically related, perception and attention are faulty, bizarre disturbances in motor activity, flat or inappropriate emotions, reduced tolerance for stress of interpersonal relations, causing patient to withdraw from people and reality, often into a fantasy life of delusions and hallucinations, due to a misinterpretation of reality.

Trauma - A severe physical injury or wound to the body caused by an external force, or a psychological shock having a lasting effect on mental life.

PSYCHOLOGICAL/PSYCHIATRIC EVALUATION TESTS

The psychological/psychiatric evaluations received from providers may often be confusing. The following are some descriptions of tests often found in evaluations and their uses.

<u>Intelligence tests</u>

Besides using intelligence tests to assess a general level of intellectual functioning, the pattern of test scores can indicate possible psychopathology.

1. McCarthy Scales of Children's Abilities (MSCA): Given to children ages 2 1/2 to 8 1/2. Test provides an assessment of cognitive, language, and motor functions. It gives a broad measure of intellectual development.

2. Slosson Intelligence Test: Brief screening device of mental ability. Does not yield a valid IQ but does indicate if further testing is needed and possibly some problem areas. Test time: 15 minutes.

3. Stanford-Binet: Can be administered to persons ages 2-18. The six tests are grouped into each age level. No individual takes all the test items. You begin at a level slightly below estimated level of functioning and continue to a level where all tests are failed. The resulting scores correlate highly with academic achievement. Test time: from 30 minutes to an hour and a half depending upon the age of the examinee.

4. Wechsler Intelligence Scales for Children - Revised (WISC-R): The subtests are classified into verbal and performance scales. Raw scores on each subtest are transmitted into scores by age group. The test can be administered to children ages 6-17. Test time: 60 - 90 minutes.

5. Wechsler Preschool and Primary Scale of Intelligence (WPPSI): Assessment of intelligence in 4 to 6 year old, yielding a verbal and performance profile, as well as a full scale IQ. Test time: 60 minutes.

Neuropsychological tests

These tests are often indicators of organicity or brain damage. The following two tests used as screening instruments are most successful.

1. Bender - Gestalt: Nine simple designs are shown one at a time on cards. The examinee is asked to copy each design with the sample card in front of him. The test can then be scored subjectively and/or through objective scoring systems.

   For a diagnosis of brain injury the total score should be supplemented with a number of additional observations of the child's performance including: time required, amount of space the drawings take up in the specified area, analysis of errors, observations of child's behavior, child's awareness of his errors in the drawing, placement of the drawing on the page, etc.

2. Benton Visual Retention Tests: The examinee is shown ten cards, one at a time for ten seconds each, and told to draw what is on the card. The test requires immediate recall and visumotor reproduction of drawings. Variations of this test can be given to permit a separation of perceptual from memory errors. The numbers of correct reproductions and number of errors are then compared with the expected "normal" score for each age and intellectual level.

No one test of organicity is adequate to give a differential diagnosis. Therefore, standardized batteries of tests are given to measure all significant neuropsychological skills. Two such batteries are the Halstead-Reitan and the Luria-Nebraska.

Learning Disabilities

Typically, children with learning disabilities show normal or above normal intelligence with severe difficulties in learning one or more of the basic academic skills (most often reading). To identify the learning disability the test and observation must identify:

1) The behavior disorders that result from the condition;

2) The individual combination of symptoms; and

3) The extent of specific information sought regarding the nature and extent of the disability.

The batteries assembled try to test understanding and use of written and spoken language, aphasia, disturbance of perception, short-term memory as well as auditory discrimination and motor coordination.

Bender-Gestalt and Benton Visual Retention Tests are used as well as the Illinois Test of Psycholinguistics Abilities (ITPA). The ITPA is given to children between the ages of two and ten.

Perceptual Assessment

1. Bender Visual Motor Gestalt Test: A copying test which measures visual-motor coordination. Test time: 10 minutes.

2. Beery Test of Visual Motor Integration: The Beery is a highly structured copying test with strict scoring norms. Test time: 10 minutes.

Educational Testing

1. Peabody Individual Achievement Test (PIAT): The PIAT is a wide-range screening measure of achievement in the areas of mathematics, reasoning, recognition and comprehension, spelling and general information. Test time: 45 minutes.

Language Testing

1. Test of Language Development Elementary/High School: Assessment of expressive and receptive language. Test time: 20 minutes.

2. Peabody Receptive Language Test: Measures receptive language only.

Developmental Testing - Infant and Preschool

1. Denver Developmental Screening Test: A brief screening device which assesses a child's development in personal, fine and gross motor, and language areas. Test time: 20 minutes.

2. Cattell-Binet Intelligence Test: Assessment of developmental and psychological skills. Useful for infants or very low functioning individuals. Test time: 30 - 60 minutes. (depending on age)

3. McCarthy Scale of Children's Abilities: Diagnostic assessment of cognitive, language, and motor functions. Test time: 60 minutes.

4. Wechsler Preschool and Primary Scale of Intelligence (WPPSI): Assessment of intelligence in four to six year old, yielding a verbal and performance profile, as well as a full scale IQ. Test time: 60 minutes.

Personality Assessment for Children and Adults

1. Thematic Apperception Test (TAT): The person is asked to "tell a story" about selected pictures of varying content. Responses provide insights into important personality factors. Test time: 15 - 30 minutes.

2. Children's Apperception Test: The child is asked to "tell a story" about selected pictures of varying content, which are more appropriate for children. Responses provide insights into important personality factors. Test time: 15 - 30 minutes.

3. Rorschach Method of Personality Assessment (Rorschach): Verbal responses to ambiguous ink blots are scored formally and analyzed to reveal aspects of a child's personality and social-emotional adjustment. Highly specialized training for examiners is required. Test time: 30 minutes.

Behavioral Measures

1. Devereux Behavior Rating Scales: The Devereux provides a profile of problem behaviors which may have led parents or other adults to believe that the child is having difficulties that require professional intervention.

2. Adaptive Behavior Scale: Used to assess adaptive functioning (how well a person takes care of himself, social, vocational, economic, survival skills, etc.) and behavioral difficulties. Primarily used for developmentally disabled individuals.

3. Vineland Social Maturity Scale: Scale results in a clear picture of the individual's ability to look after his own needs. Information gained through

interview with a caretaker and or subject himself. Particularly helpful with the mentally retarded. The items fall into eight self-help categories: Eating, dressing, self-direction, occupation, communication, locomotion, socialization and general.

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MEMORANDA HISTORY: